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		A. BUILDING 00 B. WING	05/12/2011

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F0000	This visit was for an Initial Certification and State Licensure Survey. Survey dates: May 10, 11, and 12, 2011 Facility number: 012523 Provider number: 012523 AIM number: N/A Survey team: Diana Sidell RN, TC Penny Marlatt RN Janie Faulkner RN Census bed type: SNF: 2 Residential: 3 Total: 5 Census payor type: Other: 5 Total: 5 Sample: 2 Residential sample: 3 Ridgewood Health Campus was found to be in substantial compliance with 42 CFR 483, SUBPART B in regard to the Initial Certification and State Licensure Survey.	F0000	The submission of this Plan of Correction does not indicate an admission by RidgeWood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of RidgeWood Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 5-17-11 Cathy Emswiller RN			
F0278 SS=A	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS) assessment was signed by a registered nurse (RN) in that the RN	F0278	Resident #2 MDS, section Z0500-A, was signed by the MDS Coordinator on 5/12/11 (Attachment #1).	05/19/2011

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	signature was found to be absent on the MDS assessment area which signified the assessment has been completed and was accurate. This deficient practice affected 1 of 2 residents in a sample of 2 residents reviewed for completeness of the MDS assessment. (Resident #2) Findings include: The clinical record of Resident #2 was reviewed on 5-10-11 at 12:35 p.m. In review of the MDS admission assessment, dated 5-3-11, indicated a lack of an RN signature in the section for the "Signature of Persons Completing the Assessment or Entry/Death Reporting". The signature in this area is utilized to indicate the RN who verified the completion of the MDS assessment. In an interview with RN #1 on 5-12-11 at 9:50 a.m., she indicated this was the first MDS assessment she had completed. She indicated she did not know that she needed to sign the bottom of the page ["Signature of Persons Completing the Assessment or Entry/Death Reporting"]. She indicated she had signed at the top of the page "where everyone else signs," and indicated the page of "Signature of Persons Completing the Assessment or Entry/Death Reporting".		All other MDS were audited by the Director of Health Services (DHS) to ensure signatures with no other deficient practice noted by 5/19/11 (Attachment #2). To ensure continued compliance, the MDS Coordinator #1 and the other MDS Coordinator have been re-educated by the DHS regarding signature requirements on the MDS by 5/19/11 (Attachment #3). 100 % of MDS will be audited for signature by the DHS or designee until 100% compliance is reached X 2 months (Attachment #4). Ongoing monitoring will also occur in Monthly QA meetings which will require action plans be developed until compliance is maintained. Monitoring will also occur quarterly through Clinical Support Evaluation and semi-annually through Peer Review Process.	

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	3.1-31(h)			
R0035	(j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. (3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication. (5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility. (6) Be afforded confidentiality of treatment. (7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities. Based on record review and interview the facility failed to develop a service plan that included a resident's need for	R0035	Resident #5 Service Plan has been updated to include nursing interventions:	05/19/2011

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	monitoring of medication side effects and interactions for 1 of 3 residents reviewed for service plans in a sample of 3. (Resident # 5) Findings include: During the initial tour with the Director of Health Services [DHS] on 5/10/11 at 10:45 A.M., the DHS indicated Resident # 5 was alert, oriented, and independent. The DHS indicated Resident # 5 uses a walker independently, but calls for assistance since she fell on 5/5/11. On 5/10/11 at 4:00 pm, the review of clinical record indicated Resident # 5 was admitted to the facility on 5/3/2011, with diagnoses that included, but were not limited to, insulin dependent diabetes mellitus, coronary artery disease, schizophrenia, anxiety, depression, hypertension, arthritis, and dementia. Review of facility "ASSISTED LIVING GUIDELINES"- "GUIDELINES FOR EVALUATION AND SERVICE PLAN", provided 5/12/11 at 2:00 pm by the corporate nurse consultant as their current policy and procedure for service plans, indicated: "Purpose: To provide documentation of a nursing evaluation of functioning and care needs and develop a plan of care in response to identified		a.) Monitor for adverse side effects or interactions of medications; b.) Monitor labs as ordered; c.) Consult with ophthalmology prn (Attachment #5). Resident #5 MD was notified and new order received for lab monitoring. I.e. CBC. Liver function test by the Director of Health Services (DHS) by 5/19/11 (Attachment #6). An audit of residents' Service Plans was completed by the DHS by 5/19/11 to ensure that all residents on psychotropic medications have interventions in place for monitoring of adverse side effects, interactions and recommended labs (Attachment #7). To ensure continued compliance, the nursing staff was in serviced by the DHS on 5/19/11, regarding interventions for psychotropic drug use and monitoring of adverse side effects, interactions, and recommended labs. (Attachment #8). Service Plans will be audited by the DHS or designee to ensure that interventions for psychotropic drug use and monitoring of adverse side effects, interactions and recommended labs are in place (Attachment #9). The audit will continue X 2 months. Ongoing monitoring will also occur in Monthly QA meetings which will require action plans be	

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	results." "Procedure: 1. Upon admission, monthly and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychological functioning and care needs." 2.... Review of Resident # 5's service plan completed by the DHS on 5/3/11 failed to include monitoring the resident for side effects or drug interactions related to the use of thioridazine for treatment of schizophrenia. Review of Thioridazine in the "Nursing 2010 Drug Handbook" on page 674, the "Black Box Warning" indicated Thioridazine has been shown to prolong the QT interval that may cause arrhythmia's and sudden death. Nursing Alert indicated to monitor for tardive dyskinesia and monitor periodic blood tests "CBCs and liver function tests" and opthalmic tests with long term use. Review of Physician's Orders dated 5/3/11, indicated "A1C (a lab test to check the average blood glucose level during a 1 to 4 month period) q [every] 6 months and was the only lab order as of 5/12/11. During an interview with the facility Social Services (LSW) on 5/12/11 at		developed until compliance is maintained. Monitoring will also occur quarterly through Clinical Support Evaluation and semi-annually through Peer Review Process.	

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	11:20 AM, she indicated that a psychologist was following Resident # 5 at another facility and that he will continue to follow and monitor resident at Ridgewood Health Campus. The LSW stated, "I will do care plan and monitor resident's behaviors and moods." "Her moods and behaviors are stable at this time." In a interview on 5/12/11 at 1:50 pm, with the corporate nurse consultant, she indicated that they do not need care plans on the assisted living side and to check their certified resident care assistant [CRCA] sheets for more information. On 5/12/11 at 1:55 pm, during an interview with Employee # 8/CRCA she indicated that she uses an Assisted Living CNA Worksheet to document daily care activities on the 2nd page and she reports to her charge nurse and reports to the oncoming shift from this form. The 1st page has all the residents on Assisted Living with name and room number with assistance needed by each resident and a place for comments for any special needs or behaviors. Review of needs for Resident # 5, indicated she has an assist bar for transfers, toilets self, uses a walker for ambulation, is on a regular diet, is a fall risk, showers in the AM, and to monitor moods and behaviors. Employee			

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	# 8/CRCA indicated she would notify her charge nurse and the oncoming CRCA of any moods or behaviors that occurred during her shift.			
R0117	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. This state residential rule was not met as evidenced by:	R0117	The staff member in question obtained her First Aid certification on 5-13-11 (Attachment #10). All personnel files of nursing	05/19/2011

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	Based on interview and record review, the facility failed to ensure that one staff member working on the residential care unit had current first aid training for 7 of 21 schedule days. Findings included: Employee personnel files were reviewed on 5/12/11 at 10:00 a.m. and indicated a total of 7 nursing staff who had first aid training. Review of the nursing schedules from April 30 through May 11 indicated the following days lacked one nursing staff member on site who held a current first aid training certificate: - 4/30 on third shift - 5/1 on third shift - 5/4 on third shift - 5/5 on third shift - 5/6 on third shift - 5/10 on third shift - 5/11 on third shift A policy and procedure for "Staff Training		department employees, who work Residential Care, have been audited and are in compliance (Attachment #11). To ensure compliance, the daily schedule will be audited every shift to ensure that at least one employee working Residential Care has evidence of First Aid training. This audit will be completed by the DHS or designee by 5/19/11 (Attachment #12). 100% of the shift schedules will be audited by the DHS or designee on a daily basis to ensure that at least one employee working in Residential Care has evidence of First Aid training (Attachment #13). The audits will continue until 100% compliance is reached X 2 months. Ongoing monitoring will also occur in Monthly QA meetings which will require action plans be developed until compliance is maintained. Monitoring will also occur quarterly through Clinical Support Evaluation and semi-annually through Peer Review Process.	

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	Requirements", with a revised date of 5/6/11, was provided by the Executive Director on 5/12/11 at 5:07 p.m. The policy included, but was not limited to: "Purpose: To ensure the staff caring for residents have the necessary training and knowledge to meet the needs of the residents. Procedure: 1. Prior to working independently staff shall receive orientation and training which shall include, but may not be limited to...j. first aid - either a Red Cross class or training by a licensed nurse for all staff in applicable states...." During an interview on 5/12/11 at 2:49 p.m., the Corporate Nurse Consultant indicated the facility's nurses did not have first aid training. During an interview on 5/12/11 at 4:14 p.m., the Corporate Nurse Consultant indicated she could find evidence that the other staff member on the third shift had first aid training.			

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R0247	(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review the facility failed to transcribe admission orders correctly which resulted in resident receiving incorrect dose of medication for 9 days. This affected 1 of 3 residents reviewed for complete and accurate transcription of admission order in a sample of 3. (Resident # 5) Findings include: Review of "Post Discharge Instructions" for Resident #5, dated 5/3/11 at 11:15 AM, from the prior facility to Ridgewood Health Campus, indicated Resident # 5 had an order for Tylenol 325mg 2 po [by mouth] every 4 hours PRN [as needed] and at 10:00 PM for pain. Review of the MAR [medication administration record] from the prior facility indicated Resident # 5 had been receiving Tylenol 325 mg 2 tabs at bedtime routinely for pain/inflammation. Review of admission orders transcribed by the receiving nurse, indicated that a transcription error occurred with the following order: "Acetaminophen[Tylenol] 325mg tab po	R0247	Resident #5 Tylenol prescription was clarified on 5-12-11 by the physician (Attachment #14). A Medication error form was completed on 5/12/11 with physician and resident notification (Attachment #15). All medical records on Residential Care have been audited for admission transcription errors by the DHS by 5/19/11 with no deficient practice noted (Attachment #16). All nurses have been educated on proper transcription of orders by 5/19/11 by the DHS (Attachment #8). To ensure continued compliance, newly admitted residents' medical records will be reviewed for accuracy by the DHS or designee (Attachment #17). This audit will continue X 2 months. Ongoing monitoring will also occur in Monthly QA meeting which will require action plans be developed until compliance is maintained. Monitoring will also occur quarterly through Clinical Support Evaluation and semi-annually through Peer Review Process.	05/19/2011

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	q[every]hs[bedtime]". Review of Resident # 5's MAR dated 5/3/11 through 5/31/11 provided by the DHS, indicated the resident received one 325 mg tab of Tylenol at bedtime 5/3/11 through 5/11/11 which was one half of the ordered dose of Tylenol for 9 days. During an interview with Resident # 5 on 5/12/11 at 2:00 PM, the resident stated, "I have osteoarthritis in my right shoulder and have increased pain late afternoon, evenings, and bedtime always, no increase in my pain since came here, it's the same as had at [the other facility]". "I got two Tylenol when I went to bed every night there for about a year". "I don't know what strength of Tylenol they give me". During an interview with the DHS on 5/12/11 at 3:48 PM and she stated, "they called the doctor this morning and notified him about the med error from admission from (the other facility) only received one 325mg Tylenol at bedtime instead of two and he gave the nurse a clarification order to only give one 325mg Tylenol at bedtime. During an interview with Employee # 9/CCC [clinical care coordinator]/RN on 5/12/11 at 3:50 PM, she stated, "(the Corporate Nurse Consultant) asked me to			

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	call MD and notify him of med error today". During an interview with the DHS on 5/12/11 at 3:55 PM, when she came in to bring copy of clarification order on Resident # 5's Tylenol order, the DHS stated, " think it was the night shift nurse that brought it to our attention". Review of the clarification order dated 5/12/11 at 12:30 PM, "Clarification: Acetaminophen 325 mg 1 tab po at bedtime effective 5/3/11 DX[diagnosis] pain/inflammation", signed by Employee # 9/CCC/RN as the nurse receiving order."			